

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-024432

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318

1003

5762

FILED JUN 18 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) Hospital OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 4511a W. Easton	
3. NAME OF DECEASED (Type or print) First Middle Last Estelle Bowers		4. DATE OF DEATH Month Day Year 6-7-62	
5. SEX Female	6. COLOR OR RACE Col.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Tenn.	
13a. FATHER'S NAME Frank. Hayes		14. NAME OF HUSBAND OR WIFE Frank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT 4 Frank Bowers		Address 4511a W. Easton	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinoma CH hard palate 144x DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 6-7-62 to 6-7-62 and last saw her alive on 6-7-62		Death occurred at 5:07 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE H. Miller MD		22b. ADDRESS Chronic Hosp	
22c. DATE 6-12-62		22d. DATE SIGNED 8 June 62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. NAME OF CEMETERY OR CREMATORY Father Dickson	23c. LOCATION (City, town, or county) Hickwood, Missouri	
24. FUNERAL DIRECTOR Bruce Funeral Home (Washington)		25. DATE RECD. BY LOCAL REG. JUN 9 1962	
26. REGISTRAR'S SIGNATURE Rosal Smith. M.D.			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Frederick A. Stark

Licensed Embalmer No. 4599

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.